FOR IMMEDIATE RELEASE 10/18/2016

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FRAMINGHAM BOARD OF HEALTH AND FRAMINGHAM MEDICAL RESERVE CORPS HOSTING THE ANNUAL FAMILY FRIENDLY FLU CLINIC ON SATURDAY OCTOBER 22ND MCCARTHY SCHOOL 8 FLAGG DRIVE FRAMINGHAM

Framingham, MA – On Saturday October 22nd from 10 a.m. to 2 p.m. the Framingham Health Department and Framingham Medical Reserve Corps will provide free flu vaccinations for all persons age 6 months and up. The flu vaccine is one of the safest and most effective ways of preventing the flu. Everyone six months and older should get a flu vaccine each year. Keep from getting sick with the flu and keep from spreading it to your loved ones by getting vaccinated on Saturday October 22nd. We have both adult and pediatric preservative free vaccine. Please note that the nasal flu vaccine is not available this year, as recommended by the CDC, due to this year's flu strains.

Also available will be:

- High Dose flu vaccine for eligible seniors (age 65 and up)
- The "new" Prevnar 13 pneumonia vaccine.

We will have an Express Clinic Area! Come prepared using these steps at home:

- Fill out the attached flu registration form (additional information and forms can be found by visiting: www.framinghamma.gov/FluClinicInformation)
- Print the completed form and bring it with you

If you have health insurance, please bring your insurance card to the clinic. No one will be denied due to lack of insurance.

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2016 – 2017 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. Please fill out as much as possible including insurance information.

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle one)* Male Female
Street Address:*			
City:* Framingham	State:*MA	Zip:*	Phone:*( )

Insurance Information: ***Include the whole member ID number and any letters that are part of that number***

Name of Insurance Company:*	**Member ID Number**:*	**Group ID Number**: (if available)

Medicare Number ***(only if you have Medicare Part B)***	Is Medicare your PRIMARY insurance? ☐ Yes ☐ No	Is the subscriber retired? ☐Yes ☐No

COMPLETE THIS SECTION ONLY **if theperson getting vaccinated is not the subscriber**

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* ☐Male ☐ Female
Subscriber's Street Address:* (only If it is a different address from above)		
City:*	State:*	Zip: * Phone:* ( )
Patient Relationship to Subscriber: (Circle)* ☐Spouse ☐Child ☐ Other		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

COMPLETE AND SIGN

DO NOT WRITE BELOW THIS LINE

Date VIS Given & Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	Indicated for Age Group	State Supplied (Circle)	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS
	Pedi Fluzone IIV4 Quardrivalent	Sanofi	UT5594RA	06302017	**0.25**	6-35 months	**Yes**	**Yes**	**IM**	**R L Arm Thigh**	8/7/2015
	Flulaval IIV4 Quadrivalent	GSK	E97K2	05/31/2017	**0.5**	3 years and up	**Yes**	**No**	**IM**	**R L Arm**	8/7/2015
	Flucelvax ccIIV4 Quadrivalent	Sqirus	186111	05/31/2017	**0.5**	4 years and up	**Yes**	**Yes**	**IM**	R L Arm	8/7/2015
	PPSV23 (Polysacharide)	Merck			**0.5**	65 years and up*	**Yes**	**No**	**IM**	R L Arm	04/24/2015
	Td Tetanus	MDPH			**0.5**	8 years and up	**Yes**	**No**	**IM**	R L Arm	02/14/2015
	Intradermal Fluzone IIV4 Quadrivalent	Sanofi	UT5570AA	06/30/2017	.1	18-64 years	No	**Yes**	ID	R L Arm	8/7/2015
	Fluzone High Dose IIV3 Trivalent	Sanofi	UI637AA UI689AB	03/12/2017 4/26/2017	0.5	65 years and up	No	**Yes**	IM	R L Arm	8/7/2015
	Fluzone IIV4 Quadrivalent	Sanofi	UI684AD UI673AA	06/30/2017	0.25-0.5	6 months and up	No	**No**	IM	R L Arm	8/7/2045
	Prevnar PCV 13 (Conjugate)	Pfizer	N16561	09/2017	0.5	65 years and up*	No	**Yes**	IM	R L Arm	11/05/2015

For children 18 years of age and younger:

- ☐ IS NOT Vaccine For Children eligible: Has health insurance and is not American Indian (Native American) or Alaska Native
- ☐ IS for Children (VFC) Program eligible because child
  - ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
  - ☐ Does not have health insurance
  - ☐ Is American Indian (Native American) or Alaska Native

Provider Name: Framingham Board of Health MDPH PIN Number 10510 150 Concord Street Framingham, MA 01702 Signature of Administrator